When to leave in the gall bladder: If it is not clearly and definitely diseased, as discussed, *i.e.*, thin walled with no stones, easily collapsible.

Drain the gall bladder: 1. If there is severe acute inflammation with edema of the ducts and gastrohepatic omentum and pancreas.

2. If there is edema and lymphangitis of the entire pancreas.

3. If there is a question of carcinoma of the common duct below the cystic duct or of the pancreas, do a cholecystduodenostomy or a cholecystgastrostomy.

In closing, I should like to say that I believe it is poor surgery to remove a gall bladder without pathology simply because it is in the field of operation. Such a cholecystectomy will not relieve the symptoms for which the patient was explored.

Summary of Papers Delivered Before the Academy at the Stated Meeting of April 1, 1926

THE TREATMENT OF CHRONIC GALL BLADDER DISEASE

ALBERT F. R. ANDRESEN

1. Chronic cholecystitis is due to focal infection—removal of all infective foci is therefore the first requisite in treatment.
2. The diseased gall-bladder, with thickened wall, cannot empty itself efficiently. Reflex irritation and gastro-duodenal disease produce anorexia. Food in the duodenum is the stimulant to gall-bladder emptying. Insufficient food therefore increases biliary stasis. Frequent feedings produce efficient biliary drainage and are necessary in treatment of chronic cholecystitis.
3. Surgical treatment is necessary in complicated cases—many cases of stones, adhesions and deformities. Ten per cent. of cases may require operation.
4. Thorough and prolonged post-operative treatment is necessary to prevent the complications due to biliary stasis.

FOLLOW-UP OF ONE HUNDRED CASES OF GASTRO-DUODENAL ULCER, TREATED MEDICALLY

BURRILL B. CROHN

1. Immediate end-results of medical treatment are satisfactory in approximately 84 per cent. of all cases of gastro-duodenal ulceration.
2. Relapses and recurrences take place with greatest frequency during first year; from then on the incidence of relapses diminishes.
3. A follow-up survey over 4 years is a demonstration of the law of diminishing returns. The shorter the period of observation the better the apparent end-results. The longer the survey extends the lower sinks the percentage of eventual and permanently cured. The percentage of cases which have submitted themselves to later surgical treatment is surprisingly high.
4. The shorter the duration of symptoms before treatment is instituted the better the outlook. The more chronic long-course cases show less optimistic end-results.
5. The younger group of patients, those under 30 years of age, give far better results than those of ulcer in older persons. Still a very satisfactory percentage of ulcers heal even in the far older decades.
6. Gastric and duodenal ulcers behave alike as regards end-results and cures. There is little difference to be seen in the two groups of cases.
7. Hemorrhage cases followed over a course of years behave in a similar manner to ulcers as a general group. Recurrent hemorrhages are infrequent and not dangerous nor is perforation more common. Hemorrhage cannot be considered as a remote threat to life nor as an immediate argument for operation.
8. Penetrating ulcers of the stomach show very satisfactory end-results after medical treatment. The life-cycle of ulcer is here seen in its most typical form. The end-results are good; over 60 per cent. show cure.